

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
6241 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 28231											
1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Colorado</i> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Haldorf</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Littleton 44x-3</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <i>Colorado</i>					
3. NAME OF DECEASED (Type or print) First <i>ALVIN</i> Middle <i>C.</i> Last <i>BIRZA</i>						4. DATE OF DEATH Month <i>6</i> Day <i>15</i> Year <i>1957</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-9-35</i>		9. AGE (In years last birthday) <i>22</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <i>NAVY</i>				11. BIRTHPLACE (State or foreign country) <i>Colorado</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles</i>						14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>Yes</i>						16. SOCIAL SECURITY NO. <i>437-08-55</i>					
17. INFORMANT <i>US NAs - Potomac River, Md.</i>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>fractured skull</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>6-15-57</i> <i>6-15-57</i>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Riding as outside front seat passenger of 3 in a convertible. Conv. made a turn and grazed a tree as Mr. Birza's head hit</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i>1</i> a.m. <i>6-15-57</i> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Haldorf</i>					
20f. (City or town) <i>Haldorf</i>						20g. (County) <i>Chas</i>					
20h. (State) <i>Col</i>						20i. (Country) <i>Free</i>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>E. J. EDELEN</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>						DATE SIGNED <i>6-15-57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANSPORTED</i>						22b. DATE THEREOF <i>6-18-57</i>					
22c. NAME OF CEMETERY OR CREMATORY <i>P.B. Robinson - Leonardtown, Md</i>						22d. LOCATION (City, town, or county) (State) <i>DENVER, Colorado</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.B. Robinson</i>						24a. REC'D BY REGISTRAR <i>Alfred L. Hauser</i>					
ADDRESS <i>Leonardtown, Md</i>						24b. REGISTRAR'S SIGNATURE <i>Alfred L. Hauser</i>					

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Police Officer		12. Signature of Witness	
13. Signature of Physician		14. Signature of Nurse		15. Signature of Other	
16. Signature of Other		17. Signature of Other		18. Signature of Other	
19. Signature of Other		20. Signature of Other		21. Signature of Other	
22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other	
40. Signature of Other		41. Signature of Other		42. Signature of Other	
43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other	
52. Signature of Other		53. Signature of Other		54. Signature of Other	
55. Signature of Other		56. Signature of Other		57. Signature of Other	
58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other	
64. Signature of Other		65. Signature of Other		66. Signature of Other	
67. Signature of Other		68. Signature of Other		69. Signature of Other	
70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other	
79. Signature of Other		80. Signature of Other		81. Signature of Other	
82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other	
88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other	
94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

BUREAU V. S.

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6242  
CERTIFICATE OF DEATH

06232

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faulkner</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phy Mem Hosp</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS W. BOWLING</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 13 1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wallace T Bowlsby</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Dolman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr Margaret Crookley Dentelle</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia - renal apoplexy</u> DUE TO (c) <u>Benign prostatic hypertrophy &amp; obstruction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>Bilateral inguinal hernias &amp; prostatic obstruction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1957</u> Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>6-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-4</u> , 19 <u>57</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>La Plata, Md.</u>			
DATE SIGNED <u>6-5-57</u>							
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>6/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deatwells Mc</u>		22d. LOCATION (City, town, or county) (State) <u>Deatwells Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>[Address]</u>		24a. REC'D BY REGISTRAR DATE <u>6/10/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 3

IN 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 0217 7-12-57 et

07378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 WALDORE</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>LUTHER</u> Last <u>BUTLER</u>		4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1902</u>
9. AGE (in yrs. last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>what ever available</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John BUTLER</u>		14. MOTHER'S MAIDEN NAME <u>Georgia BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>	
17. INFORMANT <u>LENNIE KENT</u>		Address <u>921 N J AVE. SE Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 989x DUE TO <u>Commotus frons of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hit a Club</u> DUE TO <u>Hit a Club</u> (c) <u>Hit a Club</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-29-57</u> <u>6-29-57</u> <u>6-29-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hit a Club</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit a Club</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-29-57</u> Hour <u>7</u> <u>pm</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Waldorf</u> (County) <u>Charles</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-3-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cem.</u>		22d. LOCATION (City, town, or county) <u>Waldorf</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>M. L. Mowrey</u>	

DATE SIGNED

7-1-57



MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 8 1957

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-58 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06233

6244

## CERTIFICATE OF DEATH

Reg. Dist. No. 106

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Rural-Indian Head Md</u>		<u>6 yrs.</u>		TOWN <u>Rural-Indian Head Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>George Carroll Casto</u>				<u>6-8-57</u> <u>19</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<u>Male</u>	<u>White-US</u>	<u>Married</u>	<u>9-22-1889</u>		<u>67</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if <u>Hospital Attendant</u> )		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Medical Care</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Morgantown-West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>UNK</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNK</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>220-0775</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Wife-Mrs Geo Casto, Bryans Road Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>General Asthenia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>One Month</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchio-Genic Carcinoma</u>				<u>One Year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Metastases</u>				<u>6-Mths</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>August-1</u> , 19 <u>56</u> , to <u>6-8-57</u> , 19....., that I last saw the deceased alive on <u>6-8-57</u> , 19....., and that death occurred at <u>2:30P</u> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>James Stendrews</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>17-Potomac Ave Indian Head Md</u> <b>DATE SIGNED</b> <u>6-8-57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>June 14/1957</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Placid Hill</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Houston County, Ala</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Odey Price</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hunt &amp; Funeral Home</u> <b>ADDRESS</b> <u>Walden St.</u>			
<b>DATE</b> <u>JUN 12 1957</u>							

# CERTIFICATE OF DEATH

Form No. 10-57

TO BE FILLED OUT BY THE REGISTRAR

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

PERIOD OF ILLNESS

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

PERIOD OF ILLNESS

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

SEX

RACE

EDUCATION

OCCUPATION

BUREAU V. 8

JUN 12 1957

RECEIVED

INDICATOR



06234

6245

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>CHARLES</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>CHARLES</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>	LENGTH OF STAY (In this place) <u>2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WICOMICO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS MEMORIAL</u>		STREET ADDRESS (If rural give location) <u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JOHN</u> (First) <u>CARROLL</u> (Middle) <u>CLEMENTS</u> (Last)		<b>4. DATE OF DEATH</b> (Month) <u>6</u> (Day) <u>8</u> (Year) <u>1957</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>OCT 19 1895</u>
<b>9. AGE last birthday</b> <u>61</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>STOREKEEPER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RETAIL</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>CHARLES COUNTY, MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13. FATHER'S NAME</b> <u>ROBERT LEE CLEMENTS</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>FLORENCE THOMPSON</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>YES</u> (If Yes, give war or dates of service) <u>WWI</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>MARY L. CLEMENTS WICOMICO, MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>153X IMMEDIATE CAUSE</b> (A) <u>INTESTINAL OBSTRUCTION</u>			<u>3 DAYS</u>
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u>NEOPLASTIC PERITONITIS</u>			<u>3 MOS.</u>
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <u>ADENOCARCINOMA OF APPENDIX</u>			<u>14 MOS.</u>
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b> <u>6-7-57</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>EXTENSIVE ADENOCARCINOMA - ABDOMEN</u>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>APRIL 6, 1956</u>, to <u>JUNE 8, 1957</u>, that I last saw the deceased alive on <u>JUNE 8, 1957</u>, and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>L. J. JARVIS</u> M.D.		<b>DATE SIGNED</b> <u>6-8-57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>6-11-57</u>	
<b>NAME OF CEMETERY OR CREMATORY</b> <u>ST MARY'S CEM.</u>		<b>LOCATION (City, town, or county)</b> <u>NEWPORT, MD.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Julia Pope</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HUNT FUNERAL HOME</u>	
<b>ADDRESS</b> <u>WALDOFF, MD.</u>			
<b>DATE</b> <u>JUN 12 1957</u>			

1957 12 12

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# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## 6246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06235

Reg. Dist. No.

160

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHARLES</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN</u> c. LENGTH OF STAY IN TB <u>16 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN</u> d. STREET ADDRESS <u>1 (RURAL)</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>WARREN LEVI DENT</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>JUNE 12 1957</u>					
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>W-U.S.</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAY 20, 1875</u>		<b>9. AGE</b> (In years last birthday) <u>82 yrs.</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>U.S. CIVIL SERVICE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FOREMAN</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>FREDERICK DENT</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY DENT</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <u>MRS. WARREN DENT: BRYANTOWN, MD</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART</u> <u>ARTERIO-SCLEROTIC DISEASE (CARDIAC FAILURE)</u> DUE TO (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PR MARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <u>NO</u>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>John N. Griffin</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>EXAMINER'S NAME (Type)</b> <u>John N. Griffin</u>				<b>DATE SIGNED</b> <u>6/12/57</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>June 15, 1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Old Fields</u>		<b>22d. LOCATION (City, town, or county)</b> _____ (State) _____			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hunt Funeral Home</u>				<b>ADDRESS</b> <u>Washington Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUN 17 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>John N. Griffin</u>	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06236

## CERTIFICATE OF DEATH

6247

Item 7 File 3-16 6-19-57 at

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		STATE <u>Maryland</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		LENGTH OF STAY (In this place) <u>7</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>			
HOSPITAL OR INSTITUTION OR PHYSICIAN'S MEMORIAL HOSPITAL STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>William A. Dyson</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 15 1957</u>			
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>Col.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> <u>78</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b>	
<b>10a. USUA. OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Sidney Dyson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sophie ?</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hattie L. King Wash. D.C.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>hemorrhage into meningis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>12 AM</u>, 19<u>57</u>, to <u>15 June</u>, 19<u>57</u>, that I last saw the deceased alive on <u>14 June</u>, 19<u>57</u>, and that death occurred at <u>8:20 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u>				<b>DATE SIGNED</b> <u>6-15-57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>24. REC'D BY REGISTRAR</b>			
DATE THEREOF <u>6-19-57</u>		NAME OF CEMETERY OR CREMATORY <u>Metropolitan M. E.</u>		LOCATION (City, town, or county) <u>Pomonoke Md.</u>		(State)	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>				<b>26. ADDRESS</b> <u>Barnes &amp; Matthews 1314-4th St. S.W.</u>			



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JUN 17 1957

BUREAU V. E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6248 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06237

Reg. Dist. No. 10-6

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. LENGTH OF STAY IN 1b <u>x2 Potomac Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Dispensary</u>			d. STREET ADDRESS <u>56 Elder Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Milton</u> Last <u>Forestell</u>			4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-96</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Catering Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civ. Serv. (Ret)</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>William Forestell</u>		
14. MOTHER'S MAIDEN NAME <u>Not Known</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES World War I</u>		
16. SOCIAL SECURITY NO. <u>220326172</u>			17. INFORMANT <u>Mrs E M. Forestell, Indian Head, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4 a.m. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Chronic Myocarditis</u> DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Chronic Myocarditis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had Coronary Occlusion 2 years ago and was under treatment</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Herb 18</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Herb 18</u>	
20f. (City or town) <u>Indian Head</u>		20g. (County) <u>Charles</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Frank A. Susan</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Frank A. Susan M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>			22b. DATE THEREOF <u>6/19/57</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Burlington Hall</u>			22d. LOCATION (City, town, or county) (State) <u>Arden Park Va.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. ...</u>			24a. REC'D BY REGISTRAR DATE <u>4/13/57</u>		
			24b. REGISTRAR'S SIGNATURE <u>City of ...</u>		

DATE SIGNED

6-13-57

BUREAU Y. B.

JUN 20 1907

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A13ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06238  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Date of admission before admission) a. STATE <i>Md</i> b. COUNTY <i>Chas</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ripley</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>SANDRA ROBBIN GILROY</i>		4. DATE OF DEATH Month <i>6</i> Day <i>26</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-31-56</i>
9. AGE (In years last birthday) <i>1</i> yrs		IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i>	IF UNDER 24 HRS. Hours <i>1</i> Min. <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Floyd Collins Gilroy</i>	
14. MOTHER'S MAIDEN NAME <i>Dorothy Mae Johnson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombotic cerebro hemorrhage</i> DUE TO <i>Crushed Skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <i>Truck ran over head</i> DUE TO (b) <i>Crushed Skull</i> (c) <i>Truck ran over head</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6-26-57</i> <i>6-26-57</i> <i>6-26-57</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 78) <i>Truck backed over its head while child at play</i>	
20c. TIME OF INJURY Month, Day, Year <i>6-26-57</i> p. m. <i>11:00</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Ripley</i> (County) <i>Chas</i> (State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>6-29-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>West Rest</i>	22d. LOCATION (City, town, or county) (State) <i>Ripley Chas Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles F. ...</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>7/1/57</i>
		24b. REGISTRAR'S SIGNATURE <i>Julia H. Pacey</i>	

DATE SIGNED

*6-26-57*

U. S. A.

1957

W. A. R.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06239

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

6250

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles Co</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lopata md</u>				TOWN <u>Belair md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physician's Office</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Infant</u> (First) (Middle) (Last)				<u>June 14</u> (Month) (Day) (Year) <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 13 1957</u>	9. AGE last birthday <u>1</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Charles Co md</u>			
13. FATHER'S NAME <u>Leonard Harnes</u>				14. MOTHER'S MAIDEN NAME <u>Ann Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Leonard Harnes</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1640 IMMEDIATE CAUSE (A) <u>Lupus erythematosus</u>				INTERVA. BETWEEN ONSET AND DEATH <u>6 1/2 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>and</u>				<u>6-17-57</u>		<u>Common Property</u>	
24. REC'D BY REGISTRAR				25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>6/18/57</u>				<u>Julia H. Pacey</u>		<u>Archard Dr. e. Lopata md</u>	

4000141XV10

BUREAU V. S.

NOV 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06240

Reg. Dist. No. 105

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LARRY</u> Middle <u>ELROY</u> Last <u>HAWKINS</u>				4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-1917</u>	9. AGE (In years last birthday) yrs. <u>40</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min <u>0</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>White Plains, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WARRICK A HAWKINS</u>				14. MOTHER'S MAIDEN NAME <u>EDNA CAMPBELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Warrick Hawkins</u> Address <u>White Plains, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO (b) <u>Aspiration of Contents</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>6-28-57</u> <u>6-28-57</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> AM <u>PM</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>White Plains, Charles</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. EDELEN</u>				DATE SIGNED <u>6-28-57</u>			
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) (State) <u>St. Joseph's</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warrick Hawkins</u> ADDRESS <u>White Plains, Md</u>				24a. REC'D BY REGISTRAR <u>Warrick Hawkins</u>		24b. REGISTRAR'S SIGNATURE <u>Warrick Hawkins</u>	
				DATE <u>JUL 2 1957</u>			

THE UNIVERSITY OF CHICAGO

OF THE EAST ASIAN LIBRARY  
UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6252

CERTIFICATE OF DEATH

06241

Reg. Dist. No.

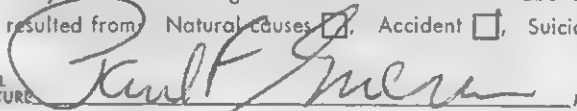
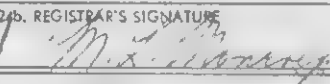
1 PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>DONALD LEE HOOD</b>		4. DATE OF DEATH <b>JUNE 15 1957</b>	
5 SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 6 1945</b>
9. AGE (In years last birthday) <b>12</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>school</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>school</b>	
11 BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>JAMES HOOD</b>		14. MOTHER'S MAIDEN NAME <b>MAE PEARSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>MRS. MAE GORDON</b>		Address <b>WALDORF, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, Pulmonary</b> DUE TO <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of Primary of Lungs</b> (c) <b>Cancer of Primary of Lungs</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 12, 1957</b> to <b>June 15, 1957</b> , that I last saw the deceased alive on <b>June 12, 1957</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>Waldorf, Md.</b> DATE SIGNED <b>6-17-57</b>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-18-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
JUN 19 1957  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06242		
6253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 105		
1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-- Charles Pr. Geo.</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First <b>EUGENE</b> Middle <b>CLARENCE</b> Last <b>INGRAHAM</b>			4. DATE OF DEATH		Month <b>June</b> Day <b>19</b> Year <b>1957</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/2/1912</b>		9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Parts Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Edward D. Ingraham</b>					14. MOTHER'S MAIDEN NAME <b>Emma L. Tower</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>578 01 2008</b>			17. INFORMANT <b>Mireta R. Ingraham</b> Address <b>1606 17st, SE Wash., D. C.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty Liver</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE 					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>6/19/57</b>				
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>6-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Paul's</b>			22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>					ADDRESS <b>Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 25 1957</b>		24b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6254 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07384

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>The Victoria</i> c. LENGTH OF STAY IN 1b <i>1 1/2 day</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Washington, D. C.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X-3</i> d. STREET ADDRESS <i>1506 "R" St., N. W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>RICHARD</i> Middle <i>F</i> Last <i>JONES JR</i>		DATE OF DEATH Month <i>6</i> Day <i>30</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 6 1919</i>
9. AGE (In years last birthday) <i>37</i> yrs.		10. IF UNDER 1 YEAR Months <i>3</i> Days <i>7</i>	11. IF UNDER 24 HRS. Hours <i>3</i> Min. <i>7</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sanitary Dept. DC. Boro</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DR</i>	
11. BIRTHPLACE (State or foreign country) <i>DR</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Richard E. Jones Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Lodie Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates or services)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> DUE TO <i>Capsize Boat</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Capsize Boat</i> DUE TO (c) <i>Capsize Boat</i> INTERVAL BETWEEN ONSET AND DEATH <i>6-30-57</i> <i>6-30-57</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i>Boat Capsize</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>6-30</i> p. m. <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>River</i>	20f. (City or town) <i>McConica River</i> (County) <i>Charles</i> (State) <i>MD</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelman</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. Edelman M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-5-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mount Airy</i>	22d. LOCATION (City, town, or county) <i>Washington D.C.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archant Inc</i> ADDRESS <i>Lopley Rd. Md.</i>		24a. REC'D BY REGISTRAR <i>7/6/57</i>	24b. REGISTRAR'S SIGNATURE <i>Julia H. Porey</i>

MEDICAL CERTIFICATION

RECEIVED

JUL 9 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06243

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Charles</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GEORGE</u> Middle <u>(SIMON'S)</u> Last <u>MADDOX</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>16</u> Year <u>19 57</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>June 9 1932</u>			
<b>9. AGE</b> (in years last birthday) <u>26</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>fisherman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Fishing &amp; shelling</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>W. Va</u>			
<b>13. FATHER'S NAME</b> <u>Joseph Simon</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Maddox</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or up-down) <u>  </u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Joseph Simon</u> Address <u>Marbury Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning, Found Drowned.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>Found drowned.</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>3:00</u> <u>PM</u> <u>6/15</u> <u>19 57</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Mattawoman Creek</u>			
<b>20f. (City or town)</b> <u>Near Indian Head</u>		<b>(County)</b> <u>Charles</u>		<b>(State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Paul F. Querin</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>Paul F. Querin, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>6/17/57</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>buried</u>		<b>22b. DATE THEREOF</b> <u>6/15/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Smiths Chapel</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Longan</u>		<b>(State)</b> <u>Md</u>		<b>24a. REC'D BY REGISTRAR</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert Macpherson</u>		<b>ADDRESS</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Julia H. Poy</u>			
<b>DATE</b> <u>6/18/57</u>		<b>DATE</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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JUN 21 1957

BUREAU V. S.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06244

## 6256 CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Charles</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Charles</b>	
CITY (If outside corporate limits, write RURAL or give nearest town) TOWN <b>Indian Head</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Indian Head</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>William Joseph MATTINGLY</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>June 26, 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 10, 1872</b>	9. AGE last birthday <b>85</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>S. Gov.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.</b>	
13. FATHER'S NAME <b>John T. Mattingly</b>				14. MOTHER'S MAIDEN NAME <b>Eliz. E. Franklin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mary E. Mattingly Indian Head, Md.</b>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Respiratory failure</b>				<b>1 day</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cerebral vascular accident</b>				<b>2 days</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Arterio sclerosis heart disease</b>				<b>10 years</b>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>371X</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. P. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May</b> , 19 <b>47</b> , to <b>June</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>26 June</b> , 19 <b>57</b> , and that death occurred at <b>12:20 P.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>J. Wood</b>				DATE SIGNED <b>26 June 57</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6-29-57</b>		NAME OF CEMETERY OR CREMATORY <b>St Joseph's Cem.</b>		LOCATION (City, town, or county) (State) <b>Pomfret, Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Ray Price</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>		ADDRESS <b>Waldorf, Md</b>	
DATE <b>JUL 1 1957</b>							

BUREAU V. 31

1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06049

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2nd St. Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Segettinico</u>	
c. LENGTH OF STAY IN 1b <u>4 hrs</u>		d. STREET ADDRESS <u>7509-25th Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First <u>NE MANNIS</u> Middle <u>NE</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7 1916</u>
9. AGE (In years birthday) <u>40</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles C McCauley</u>		14. MOTHER'S MAIDEN NAME <u>Betty Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-42-6103</u>	
17. INFORMANT <u>GIVEN A MANNIS</u> Address <u>7509-25th Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Abdominal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Multiple laceration and contusions</u> DUE TO <u>Multiple laceration and contusions</u> DUE TO <u>Multiple laceration and contusions</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-8</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto accident</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>2 car auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-8-57</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St. Johns</u>		20f. (City or town) <u>St. Johns</u> (County) <u>Charles</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. F. DELEN</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. F. DELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) <u>Charles</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Samuel Harris - West</u>		24a. REC'D BY REGISTRAR <u>12 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Lee Samuel Harris</u>	

MEDICAL CERTIFICATION

THIS CERTIFICATE SHALL BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM-3. PAGE 5 MAY BE RETAINED FOR YOUR FILES. FILE PAGES 1 AND 2 WITH THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED

JUN 12 1957

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

6258

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		STATE <u>Maryland</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>La Plata Md</u>		<u>3-days</u>		TOWN <u>Indian Head Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		STREET ADDRESS			
<u>Physicians Memorial Hosp.</u>		<u>11-Irwin Place Potomac Heights</u>		<u>La Plata Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Dora Posey</u>				<u>6-14-57</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>F.</u>		<u>W-US</u>		<u>Single</u>		<u>2-13-1870</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>87</u> yrs.		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Retired</u>				<u>None</u>		<u>Charles County Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>US</u>				<u>Charles Henry Posey</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Susan Julia Posey</u>				<u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT'S ADDRESS			
<u>None</u>				<u>Doris Morgan Hedges, 14-E-60th St. New York City</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Heart Disease</u>						<u>10-Yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-Sclerosis</u>						<u>Indefinite</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 1954, to 6-14-57, 1957, that I last saw the deceased alive on 6-14-57, and that death occurred at 5:15 PM from the causes and on the date stated above.							
SIGNATURE <u>James E. Andrews MD.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>6-15-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Funeral</u>		<u>6-17-57</u>		<u>St. Charles</u>		<u>Flintont Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>6/18/57</u>		<u>James H. Posey</u>		<u>Charles E. Hedges</u>		<u>14-E-60th St. New York City</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The information copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

RECEIVED

JUN 21 1957

BUREAU V. I.



## 6259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>to Carol</u> b. COUNTY <u>Georgetown</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>1 mon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>LeRoy</u> First <u>Reed</u> Middle <u>Reed</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1957</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-29</u>
9. AGE (in years less birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgetown S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Reed</u>		14. MOTHER'S MAIDEN NAME <u>Therine Conyers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>782x</u> DUE TO <u>Amorphy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stab wound of chest</u> DUE TO <u>cutting in of the gut vessel on heart</u> (c) <u>6-14-57</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stabbed by assailant</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>La Plata</u> (County) <u>Charles</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried 6-20-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown</u>		22d. LOCATION (City, town, or county) <u>Georgetown S.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Lee McPherson</u>		24a. REC'D BY REGISTRAR <u>6/20/57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Julia M. Parry</u>	

MEDICAL CERTIFICATION

THE DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 48 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 1 1967

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06247

## 6260 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Chas</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Spring Hill</i>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Spring Hill</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <i>725 Wayne Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Thomas Michael Ryan</i> First Middle Last				4. DATE OF DEATH Month <i>6</i> Day <i>8</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>19-8-31</i>		9. AGE (In years last birthday) <i>25</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Officer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A.F.</i>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Daniel Francis Ryan</i>				14. MOTHER'S MAIDEN NAME <i>Thomas Margaret</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Name <i>Capt. J. E. Bell</i> Address <i>Belling a 7 Ave N.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per type for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Skull</i> DUE TO <i>air Crushed Chest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Auto accident</i> (c) <i>Auto accident</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6-8-57</i> <i>6-8-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18). <i>Car Collision, Auto</i>					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. E. Delelen</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. J. E. DELELEN M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>6-10-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Belmont</i>		22d. LOCATION (City, town, or county) (State) <i>Chesapeake</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co.</i>				ADDRESS <i>517-11th St S.E.</i>		24a. REC'D BY REGISTRAR <i>John T. Jones</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 183. Page 1 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 12 1957

RECEIVED

6261

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>La Plata</u>				TOWN <u>Lock Point, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John W. Shorter</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 14 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 20 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John W. Shorter</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Elizabeth Shorter</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>						<u>1 yr.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				<u>Hypertension</u>		<u>7</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>6-15-57</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>6/17/57</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		LOCATION (City, town, or county) (State) <u>Charles</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Julia H. Pusey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Lee Reynolds</u>		ADDRESS	
DATE <u>6/8/57</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M.

RECEIVED

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Registrar, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07392  
182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ironsides</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ironsides</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>LAWRENCE E. STAFFORD</u>			4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23, 1904</u>	9. AGE (In years with birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Financial</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>	
13. FATHER'S NAME <u>Harry H. Stafford</u>			14. MOTHER'S MAIDEN NAME <u>Edith Bayley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>363-05-3857</u>		17. INFORMANT Address <u>Mary M. Stafford (Wife), Ironsides, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>6-30-57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. J. EDLEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-30-57</u>	
EXAMINER'S NAME (Type) <u>E. J. EDLEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Newton S...</u>		ADDRESS <u>1756 Pennsylvania Ave NW, Washington, DC</u>		24a. REC'D BY REGISTRAR <u>July 5 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W. Thompson</u>

RECEIVED

JUL 8 1957

BUREAU V. 3



6263

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bryans Road</u>		<u>20 yrs</u>		TOWN <u>Bryans Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Robert</u> (First) <u>Thomas</u> (Last)				<u>June 2</u> 19 <u>57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Widowed</u>	<u>March 17, 1848</u>	<u>109</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farm</u>		<u>Port Tobacco, Md</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Not Known</u>				<u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Gracie Thomas. Washington DC</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 8</u> 19 <u>57</u> to <u>June 2</u> 19 <u>57</u> , that I last saw the deceased alive on <u>June 1</u> 19 <u>57</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank A. Pusan</u> M.D.				ADDRESS (Street, city, town, state) <u>Indian Head, Md</u>		DATE SIGNED <u>6-2-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 5 1957</u>		<u>Prince Georges Park</u>		<u>Bryans Road Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>UNIT 1957</u>		<u>Julia Perry</u>		<u>Herbert Fordice Home</u>		<u>Waldorf Md</u>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A/5C 1-55 10M -

BUREAU N. 1

JUN 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6264 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06250  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>In-route to La Plata</u>		c. LENGTH OF STAY IN 1b <u>McConchie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Auto enroute</u>		d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>Suponne</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>McConchie, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Florence Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>---</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Luf. A. Ashburn</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-1-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. E. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. E. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prud. of Richard Thomas</u>		22d. LOCATION (City, town, or county) (State) <u>McConchie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Orhart Inc.</u>		24a. REC'D BY REGISTRAR <u>Lopler</u>	
24b. REGISTRAR'S SIGNATURE <u>---</u>		DATE <u>6/10/57</u>	

BUREAU V. S.

JUN 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06251

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>0</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville (Rural)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		■ IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>TOYE</b> Middle Last				4. DATE OF DEATH Month <b>6</b> - Day <b>9</b> Year <b>19 57</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1903</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William W. Toye</b>				14. MOTHER'S MAIDEN NAME <b>Jane Estep</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT Address <b>DeSales B. Toye, Hughesville Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STAB WOUND OF AORTA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. S. FISHER</b>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R. S. FISHER</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-12-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>				ADDRESS <b>Waldorf, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6/12/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Anna C. Cooney</b>			

DATE SIGNED

**6/9/57**

RECEIVED

JUN 13 1957

BUREAU W

6266

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LA PLATA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>WILMICO STREET</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>BERNADETTE</u> (Last) <u>WALKER</u>				(Month) <u>JUNE</u> (Day) <u>28</u> (Year) <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W. U.S.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JUNE 26, 1957</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>THOMAS JEFFERSON WALKER</u>				14. MOTHER'S MAIDEN NAME <u>ESTELLA ELIZABETH HUNT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>THOMAS J WALKER</u> <u>LA PLATA, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>EXCESSIVE PREMATURITY (EDC-10/12/57)</u>						<u>34 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>MALDEVELOPMENT OF CENTRAL NERVOUS SYSTEM</u>						<u>34 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>SYSTEM</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>MARGINAL PLACENTA PREVIA (INTERM.)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/26</u> , 19 <u>57</u> , to <u>6/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>57</u> , and that death occurred at <u>6:34</u> M., from the causes and on the date stated above.							
SIGNATURE <u>John H. Guffman</u> M.D.				ADDRESS (Street, city, town, state) <u>Hughesville Md.</u>		DATE SIGNED <u>6/28/57</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6-28-57</u>		NAME OF CEMETERY OR CREMATORY <u>St Peters Cem.</u>		LOCATION (City, town, or county) <u>WALDORF, MD.</u>	
24. REC'D BY REGISTRAR <u>JUL 1 1957</u>		REGISTRAR'S SIGNATURE <u>John H. Guffman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>WALDORF, MD.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**1** **INSTRUCTIONS** **1**

BUREAU V. E.

JUL 1 1957

RECEIVED



**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06253

6267

# CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>La Plata</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Potomac Heights Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>JOSEPH WILLIAM WHITE</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 12 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>April 18/57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>20</u> yrs.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence White</u>				14. MOTHER'S MAIDEN NAME <u>Alice Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
571.0 IMMEDIATE CAUSE (A) <u>diarrhea + dehydration</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>pneumonia</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>413x</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from 6-12, 1957, to 6-12, 1957, that I last saw the deceased alive on 6-12, 1957, and that death occurred at 9:57 P.M., from the causes and on the date stated above.</b>							
SIGNATURE <u>J. Johnson</u>		M.D.		ADDRESS (Street, city, town, state) <u>La Plata Md</u>		DATE SIGNED <u>6-12-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>6/12/57</u>		NAME OF CEMETERY OR CREMATORY <u>Old Gore Baptist Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Nanjemoy, Md</u>	
24. REC'D BY REGISTRAR DATE <u>6/12/57</u>		REGISTRAR'S SIGNATURE <u>Julia H. Bacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fairlee</u>		ADDRESS	

4000297XV6

# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME AND ADDRESS OF DECEASED

CAUSE OF DEATH

DATE OF DEATH

WILLIAM C. MOORE

BUREAU V. S.

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film 0216 6-19-57 et

06254

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring Hill</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edwardsville Pa</u> d. STREET ADDRESS <u># 7 Plymouth 75X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>EDWARD</u> Middle <u>WILSON</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-30</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u>26</u> Min. <u>26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sgt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.F.</u>	
11. BIRTHPLACE (State or foreign country) <u>Edwardsville, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Ruth (Wilson)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Capt. L.E. Bell</u>		Address <u>Bolling A.F. Base</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture base of skull</u> 816X DUE TO <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Auto accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6-8-57</u> INTERVAL BETWEEN ONSET AND DEATH <u>6-8-57</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car Collision auto</u>	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>66 301</u>		20f. (City or town) <u>Pa</u> (County) <u>Pa</u> (State) <u>Pa</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. E. DeLena</u>		DATE SIGNED <u>6-8-57</u>	
EXAMINER'S NAME (Type) <u>E. J. E. DELEN M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-10-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edwardsville Pa.</u>		22d. LOCATION (City, town, or county) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co.</u>		ADDRESS <u>517-11th St. S.E.</u>	
24a. REC'D BY REGISTRAR <u>June 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Julia Pacey</u>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 11 1957

RECEIVED